Welcome
February 14
360 Degrees of Wound Healing
Will begin at 2:00 p.m.

Housekeeping Announcements

Problems during the call?
Press *0 to be connected to the Operator.

Handouts
PDF sent with confirmation email.

If you were unable to access the handouts to print, please contact the Association at 614/436-4154 after the call and we can provide those for you.

Evaluation
Each person listening to the call must complete the evaluation form.
FAX or mail to the Association (FAX: 614-436-0939).
Recording

This live program (as well as all previous webinars) are also available via CD recording. Please note that there are no CEUs available for listening to the recording. Please contact the Association if you would like to purchase a recorded copy of a previous webinar.

Also for those listening to the recording, please note there may have been changes since the live broadcast of this program. Please contact OHCA or the speaker for clarification.

Continuing Education Credit

- Wait 24 hours and then Go to http://www.efohca.org and click on ‘Request Your Certificates’ in the column entitled Live Teleconferences & Webinars. Certificates are available for 1 year after the program date.
- Find your Facility name in the drop down list. If your facility name is not there, contact the Association office at 614-436-4154.
- You will enter all participants names at one time. Follow the on screen instructions.
- You will receive an email when your attendance has been verified and your certificates are available for download.
- Please note: this course is considered a self study course by Ohio BENHA. Administrators are reminded that BENHA limits teleconference (home/self study) credits to a total of five (5.0) per renewal period.
Today’s Format

• 90 minutes available for presentation & questions
• Questions? During the presentation: you can type your questions

There will also be time for live questions & answers at the end of the presentation and the operator will explain that procedure
Upcoming Programs:
Managing Reimbursement, RUGs and Key Reports – February 14 – 15, Columbus
Winter Conference – February 21 – 22, Columbus
Therapy Conference – March 20, Columbus

Upcoming Webinars:
February 28 - Reduce Unavoidable Hospital Readmissions
March 13 - Does Your Toileting Program Have to Go?
March 27 - Person Centered Care Plans that Work
March 28 - Ohio Nursing Home Licensure Rules
April 10 - The Who, What, When & How of Medication Administration

Today’s Speaker

Mary Jane Maloney, Chief, Clinical Operations, Northeast Surgical Wound Care (NESWC), is an Adult Health Nurse Practitioner who graduated from Case Western Reserve University with a Masters in Nursing in 1998. Her clinical nursing experience is varied as she spent a full career in the United States Navy working with sailors, marines and their families nationally and overseas, transitioning to community health with the Cuyahoga County Board of Health as a health promotions coordinator. While pursuing her MSN Mary Jane was recruited for the Director of Nursing position of Metro Health’s Emergency Department and Level I trauma center. A member of NESWC’s practice since 2001 Mary Jane has transitioned from the top clinical production clinician to the APN primary clinical trainer and quality assurance manager. She developed the current electronic health record system for the practice and is working on a combined clinical and business intelligence project for long term care facilities. Additionally, Mary Jane has presented wound healing education at national and local conferences as well as university settings. Mary Jane attained her BSN from the University of Maryland, and an MS in Health Care Services from Salve Regina College, Newport, Rhode Island. She is board certified by the American Academy of Wound Management as a certified wound specialist. Mary Jane is very active with the Ohio Association of Advanced Practice Nurses as she has been the Past President (2009-10) and was re-elected for President for 2012. Finally, Mary Jane was presented with the American Academy Award for Nurse Practitioner Clinical Excellence in Ohio for 2011 this past June in Las Vegas, Nevada.
Wound Care Program:
You need a program or at least a plan!!!!

- Policies, Procedures, Protocols?
- Standing Orders signed by Medical Director to implement protocol?
- Designated Treatment Nurse?
  - Trained? How: OJT, formal?
- Many Pros and Cons
  - Another lecture:
    - “How to Become or Have a Super Treatment Nurse”
- What does WCC mean?
  - Does it expand scope of practice? NO
  - Can an WCC RN/LPN determine etiology? NO
  - Can an WCC RN/LPN write treatments orders without calling a provider? NO
Optimization: Compromised Resident

- Pre-Wounded
  - Tensile strength at 2 years: 80%
  - Offload as if wounded
  - If reopens on your watch, it is not “present on admission”
- Diabetics
  - Keep serum glucose below 200
  - Keep HbAIC below 13
    - Good glycemic control <7.5
- Daily foot care
  - Wash feet daily with mild soap and water.
  - Clean white socks daily
  - Mild moisturizer (not between toes)
  - Antifungal powder between toes
    - Fungal infections lead to DFU
  - Alert PCP or WC provider for any skin openings/discholorations
  - DPM appointment q 90 days

Your Plan Continued...

- Skin checks?
  - Who checks – consider licensed staff
  - Who is notified?
    - Confident getting all of your wounds?
      - No- Do a skin sweep
- Do you use a Wound Clinic?
  - Pros: No cost for advanced procedures (Aligrafts, dermagrafts, etc)
  - PCP shares risk
  - Cons: Facility bears transport costs and low level debridement costs for skilled patients
    - Frequent transport of frail elderly – no control of support surfaces
    - Wound management not always congruent with LTC standards.
Your Plan Continues...

- Orientation of new nurses to your WC standards?
- Inservices on wound care?
  - Skill competency at least yearly on NPWT or just plain wound care?
- Wound Care
  - PrU’s weekly assessments
    - Staging, Etiologies?
    - Can RN/LPN determine and MD signs off?
  - Keep track of all wounds and skin conditions
  - Wounds declining – what do you do?
  - PCP’s interested or knowledgable in WC?
  - Is formulary skimpy, OK or way too much?
- Last Survey – How did you do?
  - Any major change in policy, or staffing since last survey?
  - What worries you and your staff when your window opens?

Optimization:
Compromised Resident

- Malnutrition
  - Weight loss
    - Acute Inflammatory State
    - C-reactive Protein?
    - Prealbumin/Albumin?
    - How do you determine weight loss with edema?
    - Wound improving
- Immobility
  - Say no to bedrest
  - Adherence to limitations
    - Document declination
- Right equipment
  - Foam wedges instead of pillows
  - Suspension Boots instead of heel protectors
  - PR cushions on all non-ambulatory residents
  - APM’s for all truncal wounds

Stamp out “Penny wise”, Pound foolish” mentality
Optimization: Compromised Resident

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Optimization: Compromised Resident

Dehydration (F 327)
- RISK: Diarrhea, Vomiting
  - Acute Renal Failure
- Supplement supplement oz per oz w/ water
- Elderly lose thirst drive (actually starts in your 50’s)

Incontinence
- Prevention Creams
- Heavy Duty Ointments
  - Evidenced base practice: Petrolatum, dimethicone, zinc oxide
- Use of Foley (F 315)
- Urine versus stool
  - “Brief free facility”
- Check and change adherence
- C- Dif battle gear
  - FMS
- Re-think short term Foley for IAD

Pain Management
- Pain suppresses the immune response
Wound Assessment

NOT ALL NURSES KNOW HOW TO DO ONE

Wound Measurements

- Length - widest
- Width - widest
- Depth – deepest
  - Any skin disruption is given a depth of 0.1 cm so volume may be calculated
  - Eschar is a skin disruption
  - Blisters and sDTI are given a depth of zero as epidermis is lifted, not open.
- Do not use plastic circumference tools – inaccurate
- Help your nurses w/ presbyopia: use paper measures.
  - Average age of nurse (USA): 46.8
  - Only 8% are <30
- Unsure of improvement: calculate
  - Surface: l x w
  - Volume: l x w x d
- Obtain measurements weekly.
Wound Exudate

- Characteristics
  - Serous – clear
  - Serosanguinous – clear/bloody
  - Bloody
  - Purulent
    - Liquification - good
    - Pus – bad
    - How can you tell?

- Amount: scant to copious
  - Too dry – cells stick
  - Too wet – cells drown

Periwound Edges

- Smooth, tightly adherent
- Lifting
- Rolled
- Scar/calloused tissue
- White: macerated – **drowns cells**
  (MASD – periwound wound skin damage)
Periwound with Deep Tissue Injury
Wound Bed – Granulation Tissue

Epithelialization

Medscape® www.medscape.com
Fibrin Slough

Necrotic Tissue/Eschar
Crust/Scab

Deep Tissue Injury
Let's talk about Moisture Associated Skin Damage (MASD) – (Not every wound on the BUM is pressure)

“Inflammation and erosion of skin caused by prolonged exposure to various sources of moisture.”

Four Types:
1. **Incontinence Associated Dermatitis**
   - Caused by feces/urine
   - 37.5% greater chance for PrU
   - Pain likened to that of burns
   - Many times erroneously called a Stage 2 PU
   - Skin split in gluteal cleft?

**MASD:**
**Incontinence Associated Dermatitis**

- Treatment of IAD focuses on three main goals:
  - Removal of irritants from the affected skin;
    - Brief free facility
    - Check and Change every hour when using conservative measures
    - Emollient wipes
    - Zinc oxide w/ STNA education
    - Eradication of cutaneous infections such as candidiasis (yeast)
      - Do you have a barrier cream w/ miconazole in it?
  - Containment or diversion of incontinent urine or stool.
    - Foley
    - Rectal pouch or fecal Management System
MASD - Intertrigo

Characterized by skin reddening, maceration, burning, itching. Also erosions, fissures, exudation and secondary infections.

Factors predisposed to intertrigo include obesity, skin folds, moisture, warmth, sweat retention and friction.

Treatment:
- Keep skin folds dry.
- Antifungal powders
- “Powder Prevents, Crème Kills”
- Intradry Ag (Coloplast)
- Wear bras – change daily.
- Pillow cases, towels and sheets are not recommended as they do not “wick” fluid away.

“Inflammation of two skin surfaces that are in constant contact caused by friction and sweat.”
MASD – Peristomal Moisture Associated Damage

Inflammation and skin erosion related to moisture that begins at stoma/skin juncture and can extend outward in a 4 in radius.

- Causes: stool, urine, perspiration, immersion with baths
- Obesity increases risk
- Liquid stool has higher level of enzymes
  - Ileostomy
  - Colostomy with diarrhea
- Pouch Failure – catastrophic
- Tx:
  - Wear not to exceed 4 days
  - Cut to fit barrier, may need belt
  - Polymer acrylate liquid skin protectant, i.e Marathon by Medline)

Northeast Surgical Wound Care
MASD – Periwound Moisture Associated Damage

Wound exudate caused by normal inflammatory process of wound healing.

- Overhydrated skin (maceration) delays healing, increases infection risk, increases friction risk and enlarges the wound.
- It prevents cell migration over the wound bed.

Tx:
- Liquid acrylates (Marathon by Medline)
- Zinc oxide
- Absorptive dressings
- NPWT
- Compression
Wound Documentation

- CMS in F-Tag 314 lists the following:
  - **Weekly**
  - Date assessed
  - Location
  - Exudate:
    - Color
    - Type
    - Odor
    - Amount
  - Recommended to **DO IT FOR ALL WOUNDS**.

Does your documentation meet the standard for all wounds?

- F-Tag 309 Quality of Care
  - Non-pressure related wounds
  - If they are not healing what are you doing about it?
  - Keep track of all skin issues and have MD/NP/PA determine and document etiology.

- CMS is OK with photos if there is a policy.

- Etiology must be done or confirmed by a provider who can make a diagnosis (MD, NP, PA)
  - Staging may be done by an RN or LPN after diagnosis.
  - Is Skin Tear a diagnosis? **YES**
  - Is denudement a diagnosis? **NO**
  - Is excoriation a diagnosis? **NO**
SAMPLE DOCUMENTATION

4/28/2010 9:30AM
Contacted by STNA of discolored areas found on bottom of both feet during shower. Right great toe has blood blister 1.9 cm x 1.2 cm x 0. Left great toe has blood blister 2.4 cm x 1.6 cm x 0. No drainage from either blister. “R” does not know how happened. I.M. Grate CNP notified and treatment ordered...R.U. Appy LPN

***LPN Appy completes an incident report per facility policy.

Clarification of Orders

- Order does not make sense.
- Do not have ordered supplies.
- Can not read order.
- Do not know how to perform treatment.
- Protocols DO NOT supercede a provider’s orders.
- Substitution of treatment orders is not acceptable without clarification.
Scope of Practice Issues

- Do not change a provider’s order:
  - Call the provider who wrote the order.
  - Read ORC 4723 = Ohio Nurse Practice Act

- Know your scope of practice.
  - Scope of practice does not change based on where you practice.

- NP/CNS orders are **NOT** Nursing orders.

- DON’s do not have regulatory authority to change a licensed provider’s (MD, DO, DPM, NP, CNS, PA) order without calling the provider.

Defensive Documentation

- Assess wound ASAP after notification.
- Record wound assessment, how found, what was done and what provider was informed of new finding.
- **DO NOT DIAGNOSE!!**
- Always document when provider visited or was contacted.
- **Do not write your own orders!!!**
- Document telephone call to provider when you accept a telephone order.
- **Provider co-signature will not “save” you from litigation.**
- Notify POA of when wounds found.
- Minimal weekly documentation until closed.
- If no improvement or deterioration, notify provider immediately.
- If provider fails to respond, notify PCP, Medical Director, DON and Administrator.
Wound Treatments

- Blisters
  - Do not Pop
  - Do not Aspirate
  - They are biological bandaids.
  - Pad and Protect
  - Spider Bite

Keeping Certain Wounds Dry

- Protect with Silicon dressings or non-adherent
- **No tape: not even paper on the elderly**
  - Abd pads with gauze, abdominal binder or stockinette
  - <<< Pemphigus Bullae
Say NO to moisture – Keep Dry – No Debridement

- Lower Extremity
  - Below the knee
  - Dry, adherent eschar
  - AHCPR Guidelines, 1994

- Exception:
  - Documented arterial sufficiency or
  - Eschar starts to drain or
  - Periwound cellulitis

What to do with dry wounds?

- Pad and Protect
  - Thick WHITE sock
    - Colored hides drainage
  - ABD pad and gauze wrap
  - Check for moisture
  - Alginate or 2x2’s btn “kissing” toes.
  - Mummification is not so bad!!
  - Wet gangrene is
    - Urgent surgical consult
Wet Gangrene = Wound Emergency

- Epidermal lifting
- Swelling
- Drainage
- Erythema
- Wet gangrene with Osteomyelitis
  "<<<...Required Amputation of great toe"

Wet to Dry Dressings

- “Hanging W2D Dressings out to Dry”
  - Most common dressing treatment.
  - LOTA second most common treatment.
  - Moist wound healing less than 25%
    - Not condoned by CMS if not indicated or not effective (F 314)
- Mechanical Debrider
  - Causes pain
  - Non Selective: takes the good and the bad
- Non-Occlusive
  - Problems with incontinent patients
  - Flies – Another presentation “Stop Bugging Me”
Prevention Tips

- Specialty Mattresses
  - Breathable pads
  - No motherpads
  - No doubling
  - No towels
  - No washcloths
  - No briefs – few exceptions
    - Briefs cause dermatitis
    - Overlays increase risk for falls

Factoid: Heels show hyperemia at 30 minutes with unrelieved pressure.
- Need to reposition frequently
Prevention Tips

- **Socks**
  - Thick and white
  - Prevents friction, shear
  - Keeps warm
  - Induces sleep

- **Heel protectors**
  - No better than socks
  - Do not prevent pressure
  - Do not protect toes

- **Keep wounds covered**
  - Wounds **stop healing** when less than body temp

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Prevention Tips

- **Foley or Tube Pressure Ulcer**
  - **AVOIDABLE**
  - Securement Devices
    - Bard
    - Stat Lock

- **PEG/PEJ and Suprapubic**
  - Secure devices to decrease hypergranulation
MDS Section M

- Need accurate data and etiologies
- Questions:
  - Are blisters, sDTI and eschar open or closed? If closed, are they healed?
  - Can you use the NPUAP guidelines to code the MDS?
  - Is sDTI a stage 1 or unstageable?
  - Stage 2 heel ulcer is POA. Two weeks later it is covered with eschar and now unstageable. Is it still POA?
  - Stage 3 coccyx is inhouse/facility acquired. Goes to hospital and returns as unstageable. Is it POA?

More Section M Questions to Ponder...

- New admission with POA wound to sacrum. History reports Stage 4 ulcer but wound looks like a Stage 3. What do you classify the wound as?
- If depth of wound can be measured but the wound bed is partially covered with slough or eschar, is this wound coded as unstageable?
- Is a blood blister a stage 2 or sDTI according to Section M?
- There are two pressure ulcer on the right hip separated by 0.4 cm. Do you count them as one or two wounds?
- Stage 3 PU to right heel closes b/w MDS assessments and then reopens three weeks later. Do you record closed wound and new wound?
- If a diabetic develops a pressure ulcer on the heel is it a pressure ulcer or a diabetic foot ulcer?
- Are skin tears recorded in the MDS assessment?
- The treatment for an ulcer is a bandaid. Can I code this in section M1200G as an application of a non-surgical dressing?
OOPS…OUT of TIME …Who has questions?